Teachers as health workers: Patterns and imperatives of Australian teachers' work

Tony Rossi[1], Amanda Pavey[2], Doune Macdonald[2] & Louise McCuaig[2]

[1]School of Exercise and Nutrition Science, Queensland University of Technology, Brisbane, Australia

[2]School of Human Movement and Nutrition Sciences, The University of Queensland, Brisbane, Australia

Abstract

With increasing cross-sectoral relationships and partnerships and the blurring of the boundaries of the various service sectors (Westall 2009), the membrane that is assumed separate education and health in terms of young people's wellbeing looks thinner than ever. In this project we are concerned to know what teachers do in terms of young people's health, how much time they spend doing it, and to what extent this work might be considered as *health work*? The paper is informed by a Likert style survey and semi-structured interview data collected from a large cohort of teachers employed in different school sectors across Queensland, Australia and is framed by Bourdieu's (1977) ideas around field, practice and doxa. The data suggest that teachers, often with a minimum of training undertake work that might be categorised as health work and do so with a high degree of commitment and with a growing sense of urgency but with concerns related to their competence. We consider it important to understand the reasons why and the extent to which teachers engage in work that might be more readily associated with public health and to ask "are teachers health workers?"

Key Words

Teachers' work, health work, health workers, schools

Introduction

The teaching of health and overseeing of health practices in schools is not new. Under the auspices of various policy and curriculum arrangements or school pastoral systems around the world, teachers have delivered health education curricular and/or public health programs in various forms since mass schooling became free at the point of delivery (Kirk, 1998).

The idea of teachers as *health workers* however is a more recent idea and in our view one that is perhaps more provocative. Within the context of multi-sectoral delivery of services, the idea of teachers as health workers appears to have gained momentum, as the sphere of public health has become more entrenched in the *work* of schools. In 1998, the British government published a White paper called *Our healthier nation: a contract for health* (see Gabbay, 1998). The paper unequivocally identified schools as being on the front line of health improvement, suggesting this would result in lower health costs, a reduction in health gaps and an increase in the national free from illness days.

In the US, joint statements from the likes of the American Cancer Society (ACS), the American Diabetes Association (ADA) and the American Heart Association (AHA) emphasise that schools and the work of their teachers are crucial for the wellbeing and health of the nation. According to a joint statement, “Not only do schools provide critical outlets to reach millions of children and adolescents to promote lifelong healthy behaviors, they also provide a place for students to engage in these behaviors, such as eating healthy and participating in physical activity" (ACS, ADA, AHA, n.d., para 2).

Likewise in Australia, health sector advocates argue that the “interaction between schools and young people, and the overall experience of attending school, provides unique opportunities for health promotion which can be sustained and reinforced over time” (National Health and Medical Research Council [NHMRC], 1996, p. 1). More recently, the National Health and Hospitals Reform Commission (NHHRC) recommended that one way to strengthen consumer engagement within a health system is to ensure that *schooling* is integral to health promotion. More specifically, these national health reports implore (successive) Federal governments of Australia to “Fund, implement and promote school

programs that encourage physical activity and enable healthy eating" (National Preventative Health Taskforce [NPHT], 2009, p. 145) and embed health literacy in the "National Curriculum for all schools" (NHHRC, 2009, p. 13). The recent advent of the Australian Curriculum for Health and Physical Education (a national document) demonstrates how health literacy is an organising principle in curriculum design.

Against a background of increasing concern about the health of children and young people, and its implications for shaping productive and high achieving young people, we argue there is a need to understand what and how much 'health work' is being undertaken by teachers in schools and what conditions either enable or constrain this work. Our interests therefore were three fold. First, it was important to get a sense of the approximate amounts of time spent on work associated with or designated as' health' and how such work might be categorised as such. We considered it important to understand the perceived levels of teachers' expertise for undertaking such work. Finally, we were interested to know the levels of teacher satisfaction in undertaking this work, and the degree to which the teachers perceived this as *part* of their work. Therefore the research questions upon which this study was premised were:

1. How much time is spent doing work constituted as health work?
2. What are teachers' perceived levels of expertise to undertake such work?
3. To what extent do teachers consider this to be part of their role?
4. What is the level of satisfaction experienced in carrying out various aspects of this type of work?

Schools, teachers and their 'health' work

Aldridge (1981) remarked on the increased expectancy of schools having to assume greater responsibility for the health of children, a role she argued would fall to teachers with little or no training from their teacher education programs. We suggest that the incidence and breadth of health concerns

has expanded thereby increasing the expectation of schools to contribute to better health through health promotion and health education strategies and thereby, commensurately increasing the 'health workload' on teachers. Tinning (1996) suggested that historically, schools and schooling have been tempting sites for the *inoculation* of young people against future ill health. Schools exhibit a number of characteristics which are critical to the successful implementation of health promotion initiatives including: the close and regular student–teacher contact; coverage of formative years and unique opportunities to provide a sustained and reinforced program; and the capacity to capture all children irrespective of socioeconomic status, ethnicity, or location (Basch, 2010; Marks, 2010).

There is considerable uncertainty that surrounds the capacity of schools to achieve health related outcomes for their students. Although health promotion advocates have suggested that "schools can make a difference" (St Leger, 2006, p. iii), they nonetheless claim that health related outcomes have been modest, progress slow and sustainability difficult due to health promotion's low priority and low status; insufficient teacher training; lack of resources; ad hoc support from health services; and significant gaps between the policy and practice (Basch, 2010; Marks, 2010; Mohammadi, Rowling & Nutbeam, 2010; Rowling, Booth & Nutbeam, 1998). Thus the place of health promotion (as a vehicle for 'health work') within schools remains debateable given schools' "core business is the attainment of educational outcomes" (St Leger, 2006, p. iii).

Primary schools have their own instantiations of health work that includes everything from regular head lice checks, choosing appropriate foods for school excursions and camps, through to whole-school mental health strategies (Queensland Department of Education and Training, 2011a&b). Such curricula and extra-curricula *health work* is extensive suggesting that in spite of the aforementioned uncertainty, there are growing expectations for schools to act as a 'frontline' technology of health promotion. Further, the rise of 'wellbeing' discourses across school sectors nationally and internationally (Australian Catholic University National & Erebus International, 2008) heighten the importance attributed to, and prompting our interest in, the health work of teachers in curricula, extra-

curricula and through the less tangible caring dimensions of their work (Acker 1995; McCuaig, Ohman & Wright, 2011; Noddings, 1992).

As schools are increasingly recruited to undertake health work in the name of upstream health promotion, they must consider questions about who should undertake such work? That is which teachers, what work and when, and to what extent such work should extend beyond the curriculum? Soultatou, Tzamalouka, Markatzi, Kafatos, and Chliaoutakis (2009) found in the case of mental health mentoring in Greek public schools, teachers were not only willing to adopt such mentoring roles when their training and professional development was limited, but were also prepared to undertake such roles on a voluntary basis, of their own accord, in time outside of the curriculum.

Inconsistencies of training, experience and willingness are likely to be common in the delivery of health work in schools across the globe. Australian schools face similar expectations and challenges regarding the professional preparedness of teachers, particularly in relation to mental and emotional wellbeing and health. As Graham, Phelps, Maddison and Fitzgerald (2011) indicate, whilst there is an increased expectation of teachers, the "key question emerges, then, as to how teachers perceive their role in relation to supporting children's social and emotional well-being" (p. 480). The authors suggest that, contemporary approaches to social and emotional wellbeing programs in schools are more in tune with health promotion discourses that promote a *strengths-based* focus with the child as an active participant and accompanied by a "closer attention to the role schools and teachers can and do play in supporting students' social and emotional well-being" (p. 480). Significantly in Graham and colleagues' (2011) study, the teachers overwhelmingly suggested that their training and preparation was not commensurate with the increased level of expectation and required understanding related to these health promotion endeavours. Moreover, this study alerts us to a second issue surrounding teachers' health work as we speculate the possibility that greater levels of health work are undertaken *in addition to* the day-to-day duties of teachers. One could reasonably argue that the *cost* of young people's public

health care is being increasingly deferred to schools and the teachers within them with seemingly no increase in fiduciary allocations, time or 'space'.

It is within the context of contemporary challenges that teachers, with a minimum of preparation and training, are required to deliver and oversee health work as part of the school's responsibility in creating healthy and productive citizens. In Australian primary and secondary schools, the curricula and extra-curricula dimensions of health work are shared by specialist Health and Physical Education (HPE) teachers, other generalist and specialist teachers, as well as visiting agents/agencies, reflecting more recent trends for the recruitment of out-sourced expertise and cross sectoral delivery of services (Ball, 2007, 2012; Williams et al., 2011). Such expectations sit within an education context of heightened accountability and scrutiny, in which schools and teachers are subjected performance management (Apple, 2004; Ball, 2003) where teachers' time and effort is increasingly expected to produce improved student performance outcomes on inter/national testing regimes. In our view, as the importance of preventative health care grows across all sectors and is moved ever further upstream, education, schools and the work of their teachers has been inextricably connected to new public health agendas. To date, health and education research has focused on exploring and evaluating the effectiveness, fidelity and design of health related initiatives in schools (Dusenbury et al., 2003; St Leger, 2006), with little attention being paid to understanding the impact of these new public health strategies from the perspective of teachers' recognition, engagement and personal satisfaction with the health related dimensions of their work.

Field', 'practice' and 'Doxa'

Bourdieu's (1977) concepts of field, practice and doxa provide a useful framework to locate and understand teacher's work. These concepts are helpful for considering the intersections between policy expectations (as well as broader unstated community expectations) and teacher practices in schools (see Rawolle & Lingard, 2008). Fields are social spaces that are infused with power struggles and

organizing structure (Bourdieu & Wacquant, 1992). Often fields overlap and the rules and structures of one field come to influence those of another. Field then, is generally understood as a social arena of relationships and practices through which certain values and beliefs are situated by the actions of people who maintain the relationships in the field (Wacquant, 1989). However, Bourdieu in an interview with Wacquant (1989), also referred to field as a network or a configuration of relations whereby those within the field were 'determined' by those relations. In addition, Bourdieu described how each field regardless of how it overlaps with others, generates its own values system in which the occupants of the field come to both believe and invest. In spite of Bourdieu's claim that fields constantly try to differentiate themselves from others, he also acknowledged that the limits of a field seldom observe what he called 'juridical frontiers' (Wacquant, 1989, p.39). That is fields tend not to manifest observable beginning and end points and to this Bourdieu (1989) held that the notion of a 'profession' was a 'folk' concept. This suggests that when professions are construed as fields we should not expect them to have clearly defined borders or boundaries. In the case of health this is increasingly so and to talk about the 'health profession' may be anachronistic. Referring to health as a profession may have little meaning since defining who 'works' within the health is not especially clear. It is not unreasonable to suggest the same could be said of education.

Fields reproduce and legitimate what resources (including knowledge) are available and how they might be allocated, acquired and recognised. In response to criticism of the perceived definitional ambiguity of field, Bourdieu explained that the boundaries of a field are situated at the point where the effects of the field on a person cease. Notably, Bourdieu asserts that external determinations (such as, in the case of this study, official curricula and policies) that bear on agents in a given field never apply directly, but through the social mediation of the specific forms and forces of the field, once they have been re-structured. Based on what we perceive to be a changing teacher landscape, the fields of education and health would appear to have permeable boundaries in that the effects of one field on the other are increasingly blurred. Hence the determinants of the 'field' of education are seemingly

globalized policy networks (Ball, 2012) that include discourses more commonly associated with public health. As a consequence we consider it important to understand the field of education with its curricular and extra-curricular responsibilities as it interfaces with the field of health and its attendant policies, procedures, and increasingly its personnel.

Bourdieu's (1977, 1990) notion of practice refers to the activities that people engage in for specific purposes within and across fields. Moreover, practices can be nominalised or formally sanctioned with defined the parameters of enactment of and engagement in fields. In this regard, teaching can be viewed and analysed as a practice, both in terms of the activities teachers engage in and those activities that they are expected to engage in as communicated through education policies and the expectations of the school and its community (e.g. HPE teaching, pastoral care, health professional referrals etc.). Increasingly, the external determinants from public health are also defining teachers' work. As a consequence, practices within the field of education are are perhaps being re-shaped by determinants that potentially bear scant resemblance to the professional knowledge either initially or subsequently acquired by teachers in any form of professional training.

As Bourdieu (1977) suggests, practices can only be accounted for within the objective structure that defines the social conditions of the field. The state of this structure then is shaped by the practices within it. In short it is a reflexive cycle. Bourdieu emphasizes this by arguing that each agent is both 'producer and reproducer of objective meaning' (p.79). This suggests then that meanings produced within a field are the means not only to its existence but its persistence *as* a field. Since a field is never reflexively exactly the same nor entirely different; the practices within fields adjust with the changing social conditions. Objective meaning is established through the 'coherences' within a field be they rules, myths, beliefs, or even points of law. For teachers in schools this has traditionally included policies, curricula and perhaps a sense of professional ethics and increasingly published and enforceable standards. However, teachers' work we, would argue, is being defined by the 'coherences' from outside of education to the point where the fields of health and education are a seamless construction that

serves multiple purposes in addition to educational achievement namely, the well-being of young people, the production of healthy citizens and even propping up the welfare state, which under the weight of neoliberalism continues to recede from view. Given these changing conditions we were keen to understand the degree to which health work was becoming nominalised practice for teachers in schools.

Doxa

At one level Doxa could simply be regarded as the taken for granted assumptions about a field in terms of how it is constituted and the practices that define that field. This however is rather simplistic. As lisahunter, Smith and emerald (2015) suggest: 'members of a group sub-consciously re-establish or reinforce modes of *practice* and theories about appropriate ways of doing things within their social worlds' (p.16). Hence the cultural traditions established over time within a field provide a sense of belonging and indeed security. Doxa then is about the internal logic of how a field functions and a sense that such logic underpins the *practices* of a field. As Bourdieu (1990) suggests, this creates a form of 'practical faith' that is not the adherence to dogma, rather, it is the state of the body within the context of field or the embodiment of membership (Bourdieu, 1990). Practical faith then is central to belonging to a field and what Bourdieu called 'native compliance' (1990) to the conditions of the field.

Methods

This study was developed to explore what 'health-work' teachers are actually undertaking, the time spent on such work and the degree to which teachers find such work satisfying. In addition, the study sought to understand, the level of confidence teachers had to deliver such work and how much of this work might be informed by initial or in-service teacher education programmes. The work was undertaken in schools (N=12) from all sectors (private (n=3, denominational (n=3 and government n=6) in the state of Queensland, Australia Queensland is a large state (area: over 1.8m km^2) with a

population of over 5m located predominantly on the extensive coastline or coastal plain. For all participating schools, all relevant agents and employing authorities granted ethical approval.

Participants

All teachers in this study were volunteers from within 12 schools recruited across the state. This paper includes data from 386. The schools were a balance of primary and secondary located in metropolitan, regional and more remote locations. Each teacher was provided with participant information about the study, and in turn provided informed consent prior to completing the questionnaire, and again prior to interview. Demographically, the average age of participants was 42.34 years (SD, 11.98), 32 per cent were male and 68 per cent female. The data showed that 24.1 per cent had 1 – 6 years teaching experience, the largest proportion of respondents, 33.4 per cent, had been in the teaching profession for between 7-18 years, followed by 29.3 per cent that had 19-30 years' experience, while 13.2 per cent reported being in teaching 31 years or more.

Design

Data were collected in two ways.

Part 1: Teachers' survey

The teachers completed a survey comprised of 35 questions. This was developed by the research team through a small pilot study and covered three broad potential areas of health-related work namely the curriculum, the pastoral system and extra-curricular programmes. The survey was then field tested with a group of supportive teachers from a Catholic, independent girls' school situated in metropolitan Brisbane. Feedback was provided to the research team verbally at the time of returning the completed survey, or in writing via notes made within the survey. Suggestions about how to improve the survey were considered by the team and the survey was subsequently amended accordingly. The sub-questions within each of the strands listed above included explicit questions designed to explore a range of topics including teaching health education; food and nutrition; health screening and referrals;

school health policy and compliance; pastoral care work; communicating with parents and physical activity all of which were prompted and further developed through the pilot.

Teachers were asked to consider how much time they spend on various aspects of this work in a typical week, and rate their perceived levels of confidence, expertise, and satisfaction. In addition they were asked to consider the impact of this work on the health of the students if possible. All research respondents were provided with the opportunity to complete the survey via an online link provided through e-mail or by hard copy. Appointments were made to attend staff meetings of schools when hard copy surveys were indicated as the preference. The surveys were distributed by a member of the research team facilitated by a representative 'gatekeeper' from each school. Alternatively, a web server-based software package called Lime Survey was used to collect responses using the on-line survey application. Anonymity of the respondents was assured to all but the researchers who had password controlled administrator access to the Lime Survey questionnaire. The survey (online and hard copy) incorporated a range of response format methods including a quantitative Likert Scale of five divisions and qualitative options for more free responses (e.g. open text boxes).. In total 386 teachers completed the questionnaire.

Examples of survey questions include:

> Approximate amount of time undertaken in health-related CPD courses in the last five years, e.g. first aid course, health-related postgraduate course.
>
> Please choose ONE only
>
> - o Nil
> - o 0.5-1 day
> - o 2-5 days
> - o 1-6 months
> - o 6 months-1 year
> - o 1-2 years
> - o More than 2 years
> - o Other: _____

Consider the last week, approximately how much time (in minutes) did you spend teaching health education as part of the school curriculum?

For example:

- Alcohol, tobacco and other drugs education
- Sexuality and relationships education
- Mental health and wellbeing education
- First aid and safety education
- Nutrition education

Please write your answer here:
_____ minutes

Part 2: Qualitative study

Seventeen teachers from five of the participant schools took part in-depth semi-structured interviews (between three and eight teachers volunteered from each school). Interviews lasted in excess of one hour in all cases. The interview guide, developed by the team, sought to more deeply explore trends arising from the survey data related to the core 'health-work' themes.

The research process was guided by the cooperative principle of communication as broadly discussed by Bless, Strack and Schwarz (1993) who suggested that dialogical interaction in research conversations need to be founded on four key elements or maxims; being informative, truthful, relevant and intentions of clarity. In tandem, a heuristic path was taken in the "search for the discovery of meaning and essence in significant human experience" (Douglas & Moustakas, 1985, p.40). Field notes were also taken during the interviews but were used more as memory aids than as data sources. However the field notes did help us gain a sense of the philosophical position of this group of teachers when compared across schools, systems and districts. Researcher reflectivity is acknowledged in that we co-created our understanding of health work by drawing from our own internal processes as

researchers in the field. We were mindful that we were collecting stories about the health work of teachers that "have their own truth to the participants" (West, 2001 p. 130).

To analyze the data, each researcher (n=4) independently conducted a thematic analysis of the transcribed interview data. This involved independently reading and re-reading the transcripts, applying labels, tags and codes to create 'meaning units'. These were then collated into broader themes under the umbrella of the guiding research questions. The themes were then collaboratively reviewed with the lead fieldworker for each research site leading the review process. Based on the coding and collaborative review processes, a research narrative was constructed in response to the key research questions with indicative participant responses identified. In addition we adopted an iterative process of data collection and analysis (Denzin & Lincoln, 2005), we incorporated a series of internal and group conversations as a crucial method of agreement in the qualitative analysis (as suggested by: Burgess-Limerick, & Burgess-Limerick, 1998; Denzin & Lincoln, 2005; Smith & Sparkes, 2009).

Findings

Levels of Experience, Expertise and knowledge

Pre-service training and Continued Professional Development (CPD)

To assist in understanding the depth of pre-service teacher knowledge around health-work, individuals were asked to approximate how much of their time during initial teacher education (ITE) was spent undertaking study specifically related to health. Table I shows the distribution.

Insert table 1 here

Over 40 per cent of respondents reported spending less than five per cent of their training learning about how to manage and teach health related topics in schools, moreover, over 21 per cent of teachers stated receiving no training in relation to health whatsoever. Qualitative data further supported these figures. It was common for respondents to acknowledge their level (sometimes lack) of

preparedness and expertise to cope with and manage the varied types of health work they faced in their day-to-day working week. Moreover some regarded this as a limitation of their ITE:

> I think all of that kind of training is just left out. I don't know about the uni side… I certainly don't think it prepared me for what I was going to take on. (Female teacher, regional primary school)

The survey also explored the amount of time spent on health-related training undertaken as part of Continued Professional Development (CPD) in the last five years. This could include a range of activities from first aid training to health related post-graduate study. Surprisingly, given the importance and attention ascribed to health by the various bodies we referred to earlier, nine per cent of the teachers in this study reported receiving or undertaking no CPD related to health at all in the last five years. This is captured more comprehensively in table two.

Insert table 2 here

When asked to describe the nature of this training much of the CPD undertaken by the respondents appeared to relate to health policy adherence (e.g. first aid, CPR, bullying and cybersafety awareness), that is, the compulsory elements that met expectations of Government guidelines. Further, as demonstrated by the comment from one principal below, it may be possible to suggest much of the formal CPD training noted in the table above falls within the medicalised notion of 'health work', leaving teachers to 'manage' that which falls outside this remit in other, less formal, ways (e.g. sharing of knowledge in staff room conversations or independent learning methods such as Google searches).

> We have training sessions for teachers around asthma, diabetes, anaphylaxis, epilepsy. So we do that once a year. We have health procedures, individual health plans and there's one, the critical health - critical - emergency health plans. (Female Principal, regional primary school.)

During interviews many teachers acknowledged the less standardised 'work' they had to take on, and despite having no specific training, there was still a necessity and expectation to manage complex and

difficult issues relating to the physical and psychological wellbeing in spite of this being beyond what the teachers considered to be their normal contractual duties:

> I think we're looking after the physical health of the child with food; because some of our children come with no food, having had no food for breakfast, don't have lunches. So we look after that side of things, but also the mental health and wellbeing of the children. Some of the stories that they come in with, they're not ready to sit down and learn. You need to deal with that first. So I guess you're more of a counsellor, even though we're not trained for that. Yeah, you do it. (Female teacher, regional primary school)

On occasions this work stretched beyond 'caring' for the students, reaching out to parents also:

> People [the teachers] just care and do it. We shouldn't have to do it, and we say that, we shouldn't have to be doing this. Sometimes I say to the [other] teachers if I had to spend less time parenting parents, I could spend some more time doing your assessments you need doing; but we just do it. (Male teacher outer urban secondary school)

Time spent undertaking health work and the type of work done

The categories used were established through the work undertaken with teachers in the pilot study. To develop an overview, teachers were asked the approximate time (in minutes) per week they spent undertaking various types of activities they considered to be health work. We present these data as simple means in Table 3 below.

Insert table 3 here

Across all the schools pastoral care received the greatest allocation of time from teachers in the sample group, with an average of 179 minutes per week. Reflecting on the interview material it appeared that pastoral care often took the form of building positive relationships with the students, where teachers

spent time seeking to encourage personal growth or life skills important for the development of 'healthy' and well-functioning young people:

> So I think their self-esteem is something that I'm very focused on this year, just building up and just getting some skills behind [them] so that they can find any success. Some need successes…(Male teacher, regional primary school)

We suggested in the introduction, the commitment to student health and wellbeing appears to be increasing in momentum in schools across Australia and indeed further afield. Such sentiment was clear to see in many of the teachers' comments. Many teachers spoke about paying greater attention to the less obvious indicators, for example a hungry child, and the subsequent appreciation that a child may not be in a healthy frame of mind to learn until particular issues are addressed.

> See, I think a teacher - we do everything. It's not just teaching…I think you're a mother, you're a counsellor, you're a doctor. You do everything you can for the child because if you haven't got the whole being in sync, then they're not going to learn anyway. So if we're asked to actually do our core business, we have to get all these other things wound up as well. (Female teacher, regional primary school)

> You've only got to look at the children - I can tell who hasn't had breakfast. You know that they've watched a movie because they'll tell you what movie and you know what time it was on. So you're already picking up on little critical indicators … (Male teacher, regional primary school)

For some teachers this genre of work meant adopting a nurturing or parental oriented role. During one interview it was disclosed a teacher had chosen to take on a financial responsibility to benefit the health of one child:

> It's about that relationship with those kids; you know they're having a hard time, you want to help them. You want to feed them. You want to - I've got a teacher who's willing to pay for the psychologist for a child at the moment because the parents can't afford it. People [teachers] just care and do it. (Female Principal, regional primary school)

> We've got one teacher who brushes someone's hair every day for them and talks about when's the last time you brushed it, do you shampoo it, that sort of stuff; yep, absolutely. They don't just change the clothes. They talk to them about why haven't you had a shower? Is the hot water not on at your house, or mum's washing machines broken, whatever it may be. So there's that kind of - feeding them and working with the hygiene. (Male teacher, regional primary school)

Moreover, teachers who have been in the profession a number of years were able to comment on their observed shift in defining 'health-work' and the changing expectations of their role:

> What health work is to me is - as in teaching wise - is probably educating your kids on what's healthy, what's not, for their bodies. Also, a big role that we play is - as teachers - is probably in the emotional side as well. That sort of changed from when I first began to where it is now, I think, it's come more of a - in this school - probably a more pressing issue. More than - yeah - because we see lots of different stuff every day. (Male teacher, regional primary school.)

However, unravelling the context and extent of health work appears problematic as at present 'health work' as a descriptor of teachers' work lacks clarity in the literature. During in-depth interviews teachers were invited to talk further about the types of health work they undertook within their school setting. While participants conveyed engagement across a spectrum of health work spaces, all teachers in the sample group reported providing important pastoral care for their students, such as student support and/or support with personal development. Providing support for mental health was also identified as an area of health work currently undertaken by all teachers in the sample. When asked if they

perceived these areas to be a health priority for students, teachers generally agreed that both pastoral care and mental health support held a high priority for improving the health of young people in their school. The range of health-work related tasks were shown to be varied and wide-ranging. For example mandatory health policy components (e.g. sun safe policy, road safety, stranger danger etc.), were all part of the day-to-day work of primary teachers, and of HPE teachers in secondary schools. However this is in stark contrast to more extreme and urgent types of health work that teachers referred to such as managing significant crises (e.g. complex mental health issues involving self-harm, serious child neglect, managing high risk behaviour, and even forms of abuse). Although they took on these tasks, they also expressed their concerns that this was not something they were either knowledgeable about or trained for:

> I think we've got no choice. You know, we're not trained per se for it. Like I guess I feel a lot more confident with my child safety background. However, still I'm not a psych, and I'm not a social worker. (Female teacher, regional primary school)

> Young people who have medical conditions, they have issues with bowel control and things like that so we provide hygienic spaces for them to work out of and things like that. We've had a young boy put on a temporary department of child safety care order so we provided him with a place. He hadn't slept in a house or in a recognised dwelling for four days so we provided him with food and the ability to have a clean uniform and a shower. So our definition of health work is quite broad. It sort of goes across social work as well and I do that. (Male teacher, outer urban secondary school)

Perceived levels of satisfaction

The survey asked teachers to indicate their how they felt in terms of perceived confidence, expertise and satisfaction across a range of 'health-work' tasks. The data suggest that teachers carry a substantial responsibility for educating healthy citizens, yet relatively little is known about how prepared

teachers are to undertake this work. Statistical analysis of the survey data indicates that teachers are spending approximately a quarter of their contracted time each week (based on an approximate 37 hour week – we pick this up later in the paper) undertaking a range of health-related tasks. A large proportion of this time is providing pastoral care, which also scores most highly in terms of teacher satisfaction of health-related tasks, followed by involvement physical activity – curricular and non-curricular. During interviews it was suggested that taking on a range of tasks related to extra-curricular matters led to extended working hours.

All respondents were provided with an opportunity to elaborate upon other health-work undertaken on a regular basis, which they considered not to be covered by the survey questions. Of the 386 participants, 49 (12.7%) chose to respond. These individuals, on average, reported spending 30 minutes per week/ on 'other' health-related tasks, for example, counselling or tutoring parents and teaching basic social skills to students. Of those that carried out this work 78 per cent considered spending their time on these additional roles were highly important to the health of the student. A particular area where teachers report feeling highly satisfied are communicating with parents, however, despite acknowledging this not all teachers felt it was possible to maintain a pattern of doing this indefinitely without it having a detrimental impact on their own well-being:

> Many years ago - well actually no, five years ago - I used to open my doors at eight o'clock so I would have parents that would come in and want a little - I was Dear Dorothy. I loved it because the students could go and play on the computers or go and build blocks or some of them wanted to write, it was all wonderful. But I got to a point where it was too much. I'd already done a day's teaching, the bell hadn't gone (Female teacher, semi-rural primary school).

Other notable findings show high levels of satisfaction in these areas appear to correlate to teachers' high levels of confidence and expertise in undertaking these activities. In contrast, teachers reported

feeling least confident in arranging health screening and referrals, and providing extra-curricular guidance and advice on food and nutrition where perceived expertise in these areas was reported to be low.

Insert table 4 here

We were interested to know whether schools from different SES areas allocated different or similar times to what was emerging as health work in this study. Simple independent t-tests were undertaken to test for connections between high and low SES schools and the amount of time spent on health work. Further, schools were broken down to primary, secondary or combined schools. It was apparent that from an SES perspective there were no significant differences in time spent undertaking health work. However, what is important is that all 'health work' cannot be assumed to be the same. It was apparent that whilst there were no significant differences in the time allocated, qualitative data suggest much hidden complexity and this appeared to be more closely associated with lower SES schools. We are confident then to suggest that health work is not an imperative associated only with low SES schools. However the qualitative data reveal that the type of health work undertaken by teachers was different in schools of different SES. Therefore it is what *constitutes* health work that may be of greater importance and may exert a greater degree of stress of teachers. The following comment perhaps captures what is emerging for us a key issue related to health work.

> Because there are a lot of these young people, they don't get health anywhere else. They don't get to go to a doctor regularly because either their parents can't afford it or they don't have the transportation to do so. They don't get dentistry. I can't wait for Dentacare because a number of our kids have not seen a dentist since they did their last compulsory check-up in primary school. They have ulcers in their mouth and you just look at them and you think, God. Do we have crises about whether we're doing the right thing? Regularly… when you have the same thing coming past your table time and time again it feels like a merry-go-round that you can't

get off, there's plenty of times we've sat around and gone, what are we doing? (Female teacher, regional primary school)

Discussion

The pastoral care system or structure in these schools seems to be the point of coalescence of the educational and health fields. Pastoral care has long been a feature of schooling but it is worth noting that that pastoral care as described by the teachers in this study is a long way from the 19th century English Christian origins where it generally referred to a self-reflective, moral piousness focussing on the sinful body (see Hearn, Campbell-Pope, House & Cross, 2006). Rather, pastoral care was regarded as a pivotal in the health and welfare of young people. Indeed Hearn et al (2006) suggest that modern interpretations of pastoral care relate more generally to health and wellbeing across schools in Australia with levels of commitment to such programs varying across the various educational sectors (government, non-government and non-government denominational). Best's (2002) model of pastoral care developed for UK schools reveals the degree to which it is framed by the language of health and wellbeing. In a later analysis of the Every Child Matters document published by the Department for Education and Skills (DfES) in England, Best (2007) clearly identifies schools as a primary agent for the health and wellbeing of young people and this includes strategies for keeping them safe.

The teachers in this study spent a considerable amount of time each week (just under 3 hours a week on an average) in pastoral care roles and it was identified as work that largely focussed on the wellbeing of pupils. It seems reasonable to suggest that teacher practice under the auspices of pastoral care looks increasingly like preventative health. The 'rules' and the 'relationships' within this structure are seemingly being defined not exclusively by education but also by health. If time devoted to others areas of health work that were identified are added to pastoral care, then the amount of the time devoted to health work represents a substantial commitment some of which fell outside of recognised

teaching time. The emerging picture is that, regardless of the form it takes, 'health work' represents a significant workload for teachers. In turn, this points to teachers being a vital component in the health knowledge field with the practices of teachers determining the relationships within the field, particularly the relationships between education and health.

Table four provides some indications around perceived competence and confidence to undertake health work. First, it should be noted that the majority of teachers considered all areas of heath work to be important to the children. However, perceived levels of confidence and expertise to undertake health work varied. The expertise to teach health education for example was considered high by less than 31 per cent of the cohort inevitably this was matched by a similarly low proportion of the group that had confidence to teach it. Similarly health screening and extra-curricular food and nutrition were considered important by most of the cohort but teachers considered themselves to have low competence to undertake these tasks. It is perhaps not surprising that this group showed low levels of satisfaction undertaking such health tasks also. Similarly leading programs of physical activity (either sport or health promotion interventions) was considered very important by most of the group yet confidence and competence to undertake this work was low across the group. In spite of relatively low levels of perceived confidence and expertise in some areas of health the 'juridical frontiers' (Wacqaunt, 1989) of health were not resisted. In fact being within such frontiers was regarded as crucial with some of the interview data identifying schools as perhaps the 'only' place where some children get any health care.

The practices of these teachers seem to be sanctioned by the acceptance of the overlapping fields of education and health. At the same time it makes little sense to argue which is either dominant or more important. Clearly the teachers in this study made little distinction at the pragmatic level, suggesting the social conditions that now define the field are constructed through new objective meanings ascribed to it. Hence, there are now, seemingly at least, new 'coherences' that better describe the field where 'teachers' work' takes place – it is a field as much defined by health as it is

education. As teachers have moved into this new space, it begs the question whether health work is the new 'doxa' (Bourdieu 1977), a set of assumptions about teacher practice that remain unchallenged and self-evident. It is perhaps a world of work that is reproducing itself through an adherence to a world increasingly seen as undisputed (Bourdieu, 1977). The health work practices of teachers are, as Bourdieu (1977) would suggest, "reduplicated by the institutional discourses about the world in which the whole group's adherence to that self evidence is confirmed" (p.167).

Before we conclude, it is prudent to look back on this study, and forward to future studies associated with this program of research. We acknowledge that we run the risk here of being labelled 'virtuous researchers' (ref). However a critical engagement with what is emerging in this research is crucial. We indicated at the outset, that the idea of thinking about teachers as health workers, that is part of the health work force, is recent and relatively uncommon. However as schools continue to engage with pupil health concerns that are of an increasingly complex nature then teachers it would seem, are required to undertake work that is not especially well described by the term 'teaching'. So whilst health education is a mandated part of an Australia wide (national) curriculum as part of the physical education subject area, the health work we refer to here goes beyond the enactment of curriculum. Additionally school programs of pastoral care are also being construed as 'health work'. There is no mandate for this and yet the juridical boundaries between health and education appear to be rather more porous that perhaps we have hitherto considered them to be. What perhaps is happening is boundary 'creep'. In other words there is no conspiracy of a 'take-over' of education by the health sector. Rather, the case for preventative health is a compelling discourse (ref here). The assumption seems to be that the most obvious place to commence a preventative agenda is in schools. At this point we must step back. Is our narrative one based on protectionism, to raise a fist of defiance and to resist those who choose to define teachers work in ways that might extend the expectations on teachers and yet do little in terms of status or reward? If as Bourdieu (1990) suggests social practice is the manifestation of an embodied practical logic and that such practice has a sense of purpose then we

need to be circumspect in our assessment of changes in teachers' work. As Bourdieu (1990) described, though 'practice' may not demand conscious deliberation, it comes about through "the actor's embodied understanding of how things 'are' or 'ought to be done': that is the nature of their reality (lisahunter, smith & emerald, 2015, p.6). To this end, health work is not being foisted upon a hapless teaching profession. Rather, teachers are 'reading the game' and acting accordingly. Teachers then are not submissive within the context the 'field' but actively seeking to 'safeguard or improve' (Wacquant, 1989, p. 40) their position. Whilst the 'practice' of health work makes significant demands on both the time and energy of teachers, it is increasingly regarded as a 'necessary' way to play the game. Accordingly, the question 'are teachers health workers?' remains an important one.

Conclusion

The importance attached to health work by the teachers in this study is not in dispute. Given the broad range of schools and the sample of teachers involved, it is reasonable to suggest these data are generalizable across the teaching profession in Australia. We would also suggest that these data might be informative for other jurisdictions given the consistency with much of the growing national and international literature on the role of teachers in health work. If such practices are the new doxa for teachers' work and the field of education is being steadily re-defined by preventative health imperatives then there are serious implications. First, teacher education programs, in spite of extensive reform agendas for the last 30 years, as far as we know do not include health related work as it was described to us by the teachers in this study (see Rossi, lisahunter, Christensen & Macdonald,2015). If teacher practices are changing to accommodate greater attention to health, then it seems teacher education programs may require a re-think. Similarly, the teachers in this study would prefer to have a far greater knowledge through continuing professional development (CPD) albeit in a more contradictory and nuanced manner than is presented in current health related policy and curriculum literature. CPD programs also appear to be in need of reform especially as although all schools demonstrated a

commitment to allocating time to curricular and extra-curricular health work, how the time was spent differed. The differences in the nature of health work differed across the SES divide.

Little research has been undertaken to establish the economic cost to the education sector of teachers' health related work, or conversely the economic savings for national health systems of this type of work undertaken in schools. Consequently, we argue that more research needs to be done on the time allocated to this work and what this means for the nature of a teacher's practice, the overall quality of their work given what appears to be an increased 'health work burden', and the level of expertise teachers perceive themselves to have. Where expertise and confidence are perceived to waver, the schools are now open to a range of private providers, not-for-profit organisations, and cross-sectoral contributors, keen to service these gaps (see Ball, 2012; Macdonald, Hay & Williams, 2008; Williams, Hay & Macdonald, 2011). The field, that was once understood as education has experienced a jurisdictional blurring and now functions as an upstream site for health. We suggest that there is important 'categorisation work' that needs continue so that teachers' work that is perceived more broadly to include health work can be more accurately described and thereby inform more precisely teachers' work policies, industrial agreements, and societal contributions beyond conventional and widely understood parameters of teachers' work. These challenges lie ahead of us as we expand this research agenda and data analysis into its subsequent phases.

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